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NEW DATA ON THE EPIDEMIOLOGY OF MICROSPORIA IN THE USSR

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[A Digest]

Until 1938 the only cause of microsporia known in the USSR was the Microsporum lanosum, the classic representative of zoophilous microsporons. In studies on 12,000 cultures during the 15 years previous, the Moscow Mycological Dispensary had not succeeded in finding any other form.

In 1938, however, A. M. Ariyevich recorded a case caused by Microsporum ferrugineum, evidently from the Far East, but no further instances were recorded until 1942 - 1943, when 25 cases were discovered in Tashkent among inhabitants and travelers who had arrived from other parts of the USSR.

From 1944 to 1946 this form of microsporia increased steadily in Moscow until it accounted for one third of the cases, and other cases have been reported in Tesina (Gor'kiy), Slonimskiy (Tashkent), Shakova (Ashkhabad), Yakobson (Riga), and other places.

Over 300 cases were studied at the Mycological Clinic, Central Skin and Venereological Institute, and the Mycological Department of the Children's Hospital imeni Dzerzhinskiy, as well as at the Moscow Mycological Dispensary and the Mycological Center, Zamoskvorets Rayon.

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Mycology of Microsporum Ferrugineum

Three basic types should be distinguished: (1) a small disc-like type resembling Trichophyton faviforme discoides; (2) a morel-like form resembling Achorion Schoenleini; and (3) a flaky type resembling Microsporum lanosum.

The rust color, considered characteristic of M. ferrugineum, may vary greatly or be wholly absent.

Microscopically, M. ferrugineum is characterized by absence of spindles and aleuria, a considerable number of intercalary and terminal chlamydospores, and wide mycelia.

It has always been considered anthropophilous, but the authors obtained a positive result on porpoises by infecting the hair with a specially prepared microsporum.

Clinical Diagnosis

Available hospital statistics show that the hairy parts of the head are affected in all cases. About one third also have infected areas on the smooth skin of the face and torso.

The difference between these cases and the more usual form, where all hair is more or less broken and the surface looks as if powdered with flour, is that some long, healthy hair may remain in the infected area and the area itself will be grayish and not white. In many cases there is a well-defined follicular hyperkeratosis.

Inflammatory symptoms appear for about a week in some cases and then disappear.

Among the characteristics of the disease are its rapid spread over all the hairy skin of the head and its progressive diffusive infection, which sometimes resembles the squamous form of mange and at other times resembles seborrhea.

The difficulty in diagnosing cases where there are only individual areas of infection in healthy hair contributes to the spread of the disease.

Microscopically, it differs little from Microsporum lanosum.

Epidemiological and Immunobiological Peculiarities

From the epidemiological standpoint, the chief characteristic of M. ferrugineum is its contagiosity in families and in children's institutions. Very young children are particularly susceptible. Hair cutting in barber shops with insufficiently sterilized instruments is a frequent source of infection. However, intrahospital infection or subsequent infection by other fungi, as N. A. Chernogubov and A. M. Ariyevich have also noted, is quite rare.

Experience has shown that this form of microsporia has greater resistance to treatment and a longer period of incubation than the more usual type.

To study the immunobiological peculiarities of fungi, intracutaneous tests were made with trichophytes and microsporons on more than 100 children. The great majority of cases showed negative results, proving that M. ferrugineum produces little reaction on the skin.

Treatment and Prophylaxis

M. ferrugineum resists ordinary treatments. Epilation by X-ray is difficult and must be done meticulously, especially in cases where the infection occurs on the border between the scalp and the smooth skin.

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In cases where the hair is falling out, the best treatment is the application of compresses of salicylic (12 percent) and lactic or benzoic acid in vaseline (Ariyevich's "scaling method").

To prevent infection in institutions, sick children must be isolated, instruments (for hair cutting, etc.) sterilized, and regular examinations instituted. The quarantine should continue for 4 to 6 weeks after the last case. Early diagnosis is indispensable.

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